Title 15 - Mississippi Department of Health

Part III – Office of Health Protection

Subpart 01 – Health Facilities Licensure and Certification

CHAPTER 82 MINIMUM STANDARDS FOR UTILIZATION REVIEW AGENTS

100 AUTHORITY AND PURPOSE

100.01 The following Rules and Regulations for Utilization Review in Mississippi are duly adopted and promulgated by the Mississippi State Board of Health pursuant to the authority expressly conferred by Section 41-83-1 et seq., Mississippi Code of 1972 Annotated.

100.02 The purpose of these rules and regulations is to promote the delivery of quality health care in a cost effective manner; foster greater coordination between payors and providers conducting utilization review activities; protect patients, business and providers by ensuring that private review agents are qualified to perform utilization activities and to make informed decisions on the appropriateness of medical care; and to ensure that private review agents maintain the confidentiality of medical records.

101 SCOPE

101.01 In the State of Mississippi, every health insurance plan or every insurer proposing to issue or deliver a health insurance policy or contract or administer a health benefit program which provides for the coverage of hospital and medical benefits and the utilization review of those benefits; every health insurer proposing to issue or deliver in this state a group or blanket health insurance policy or administer a health benefit program which provides for the coverage of hospital and medical benefits and the utilization review of such benefits shall:

1. Have a certificate in accordance with these regulations;

2. Contract with a private review agent that has a certificate in accordance with these regulations.

101.02 Notwithstanding any provisions of these regulations, for claims where medical necessity of the provision of a covered benefit is disputed, an insurer that does not meet the requirements of this section shall pay any person or hospital entitled to reimbursement under the policy or contract.

102 DEFINITIONS

102.01 **Appeal**: A formal request to reconsider a determination not to certify an admission, extension of stay, or other medical service.

102.02 **Attending Physician**: The physician with primary responsibility for the care provided to a patient in a hospital or other health care facility.

102.03 **Certificate**: A certificate of registration granted by the Mississippi Department of Health to a private review agent, and is not transferable.

102.04 **Certification**: A determination by a utilization review organization that an admission, extension of stay, or other medical service has been reviewed and based on the information provided, qualifies as medically necessary and appropriate under the medical review requirements of the applicable health benefit plan.

102.05 **Certification Number**: The number assigned to each certified private review agent. This number is not transferable.

102.06 **Certified Private Review Agent**: A private review agent who meets all the criteria for certification as set forth in these rules and regulations, has paid all current fees, and has been assigned a certification number.

102.07 **Concurrent Review**: Utilization review conducted during a patient's hospital stay or course of treatment.

102.08 **Consulting Physician**: A Medical Doctor, Doctor of Osteopathy, Dentist, Psychologist, Podiatrist or Chiropractor who possess the degree of skill ordinarily possessed and used by members of his or her profession in good standing, and actively engaged in the same type of practice and relevant specialty. The medical and osteopathy specialist shall be certified by the Boards within the American Board of Medical Specialists or the American Board of Osteopathy.

102.09 **Department**: The Mississippi Department of Health.

102.10 **Director**: The Director of the Division of Health Facilities Licensure and Certification of the Mississippi Department of Health.

102.11 **Enrollee**: The individual who has elected to contract for, or participate in, a health benefit plan for their self and/or their dependents.

102.12 **Expedited Appeal**: A request for additional review of a utilization review organization's determination not to certify an admission, extension of stay, or other medical service. An expedited appeal request

may be called a reconsideration request by some utilization review organizations.

102.13 **Hospital**: An institution which is primarily engaged in providing to inpatients, by or under the supervision of physicians, diagnostic services and therapeutic services for medical diagnosis, treatment and care of injured, disabled or sick persons, or rehabilitation services for the rehabilitation of injured, disabled or sick persons, and also, means a place devoted primarily to the maintenance and operation of facilities for the diagnosis, treatment and illness, disease, injury or deformity, or a place devoted primarily to providing obstetrical or other medical, surgical or nursing care of individuals, whether or not any such place be organized or operated for profit and whether any such place be publicly or privately owned. The term "Hospital" does not include convalescent or boarding homes, children's homes, homes for the aged or other like establishments where room and board only are provided, nor does it include offices or clinics where patients are not regularly kept as bed patients.

102.14 **Patient**: The intended recipient of the proposed health care, his/her representative, and/or the enrollee.

102.15 **Physician Advisor**: A physician representing the claim administrator/utilization review organization who provides advice on whether to certify an admission, extension of stay, or other medical service as being medically necessary and appropriate.

102.16 **Private Review Agent**: A non-hospital affiliated person or entity performing utilization review on behalf of:

1. An employer or employees in the State of Mississippi; or

2. A third party that provides or administers hospital and medical benefits to citizens of this state, including: a health maintenance organization issued a certificate of authority under and by virtue of the laws of the State of Mississippi, or a health insurer, nonprofit health service plan, health insurance service organization, or preferred provider organization or other entity offering health insurance policies, contracts or benefits in this state.

102.17 **Provider Utilization Review Representative**: The person(s) in a physician's office or hospital designated by the physician or hospital to provide the necessary information to complete the review process.

102.18 **Review Criteria**: The written policies, decision rules, medical protocols, or guides used by the utilization review organization to determine certification [e.g., Appropriateness Evaluation Protocol (AEP)

and Intensity of Service, Severity of Illness, Discharge, and Appropriateness Screens (ISD-A)].

102.19 **Utilization Review**: A system for reviewing the appropriate and efficient allocation of hospital resources and medical services given or proposed to be given to a patient or group of patients. More specifically, utilization review refers to pre-service determination of the medical necessity or appropriateness of services to be rendered in a hospital setting either on an inpatient or outpatient basis, when such determination results in approval or denial of payment for the services. It includes both prospective and concurrent review and may include retrospective review under certain circumstances.

102.20 **Utilization Review Plan**: A description of the utilization review procedures of a private review agent.

103 APPLICATION FOR CERTIFICATION

103.01 A private review agent who approves or denies payment or who recommends approval or denial of payment for hospital or medical services or whose review results in approval or denial of payment for hospital or medical services on a case by case basis, may not conduct utilization review in this state unless the Mississippi Department of Health has granted the private review agent a certificate.

103.02 The Mississippi Department of Health shall issue a certificate to any applicant that has met all the requirements and all applicable regulations of the department.

103.03 A certificate is not transferable. When there is a change of ownership of the Certified Organization, a new application will be required and a new number will be issued.

103.04 Any information required by the Department with respect to customers, patients or utilization review procedures of a private review agent shall be held in confidence and not disclosed to the public.

103.05 A Private Review Agent applying for a certificate shall submit the following documentation to the Department:

1. A completed application, signed and verified by the applicant;

2. Application fee of $1,000.00; and

3. A utilization review plan which shall include all of the following components used by the private review agent to approve or deny payment or recommend approval or denial of payment in advance

for proposed or delivered inpatient or outpatient care or retrospectively approve or deny under certain circumstances:

a. Elements of review for:

   i. Preadmission

   ii. Admission

   iii. Preauthorization

   iv. Second Surgical Opinion

   v. Discharge Planning

   vi. Concurrent Review

   vii. Retrospective Review

   viii. Readmission Review

b. Procedures for review, including:

   i. Any form used during the review process;

   ii. Time frames that shall be met during the review; and

   iii. A written protocol describing every aspect of the review process;

   iv. A description and examples of review criteria to be used for the review;

   v. The provisions, procedures, and time frames by which patients, physicians, and hospitals may seek reconsideration or appeal of adverse decisions by the private review agent, including:

      i. A written protocol describing the appeals procedure;

      ii. Any form which shall be completed during the appeals procedure;

      iii. Time frames that shall be met during the appeal procedure; and

      iv. The names and qualifications of personnel making final appeal determinations;

vi. The number, type, and qualification or qualifications of the personnel either employed or under contract to perform the utilization review;

vii. The policies and procedures to ensure that a representative of the private review agent is accessible to patients and providers five (5) days a week during normal business hours in this state, 9 A.M. to 5 P.M.; and that a free telephone number be provided with adequate lines available and staffed. The procedure for handling after-hours inquiries shall be specified.

viii. The policies and procedures to ensure that all applicable state and federal laws to protect the confidentiality of individual medical records are followed;

ix A copy of the materials designed to inform applicable patients and providers of the requirements of the utilization review plan; and

x. A list (names and addresses) of the third party payors for which the private review agent is performing utilization review in this state.

104 RENEWAL OF CERTIFICATION

104.01 A certificate expires on the second anniversary of its effective date unless certification has been renewed for a two (2) year term.

104.02 Before the certification expires, the certified private review agent may renew its certification for an additional two (2) year term, if the certified private review agent:

1. Is otherwise entitled to be certified;

2. Pays to the Director the renewal fee of $1,000.00; and

3. Submits to the Director:

   a. A renewal application on the form that the Director requires

   b. An update of information as required under Part IV of these rules and regulations

   c. An annual report.

104.03 The Director shall renew the certification of each certified private review agent, if the requirements of these regulations are met.

105 DENIAL OR REVOCATION OF CERTIFICATION AND PENALTY

105.01 The Director shall deny a certificate to an applicant if the Department finds that the applicant does not:

1. Have available the services of a sufficient number of registered nurses, that are supervised by appropriate physicians to efficiently carry out its utilization review activities;

2. Meet any applicable provisions of these rules and regulations relating to the qualifications of private review agents or the performance of utilization review the Department adopts relating to the qualifications of private review agents or the performance of utilization review;

3. Have policies and procedures which protect the confidentiality of medical records in accordance with applicable state and federal laws; or

4. Make itself accessible to patients and providers five (5) working days a week during normal business hours in this state.

105.02 The Director may revoke the certification of a private review agent if the Department finds that the agent:

1. Does not comply with performance assurances;

2. Violates any provision of these rules and regulations;

3. Fails to substantially meet the standards and qualifications adopted by the Director; or

4. Fails to comply with the regulations adopted by the Department.

105.03 Before denying or revoking a certificate, the Director shall provide the applicant or certificate holder:

1. Written notice of the reasons for the denial or revocation;

2. Thirty (30) days in which to supply additional information demonstrating compliance with the requirements; and

3. The opportunity to request a hearing in accordance with the Mississippi Administrative Procedures Law, Section 25-43-17, Mississippi Code of 1972.

105.04 If the applicant requests a hearing, the Director shall send a hearing notice by certified mail, return receipt requested, at least thirty (30) days before the hearing.

105.05 A private review agent may not disclose or publish individual medical records or any other confidential medical information obtained in the performance of utilizaition review activities without the patient's authorization or an order of a county, circuit or chancery court of Mississippi or a U. S. District Court. It is provided, however, that nothing in these regulations shall prohibit private review agents from providing information to the third party with whom the private review agent is under contract or acting on behalf of.

105.06 A person who violates any provision of these regulations is guilty of a misdemeanor, and on conviction is subject to a penalty not exceeding $1,000.00.

106 UTILIZATION REVIEW STANDARDS

106.01 Responsibility for Obtaining Certification

1. In the absence of any contractual agreement to the contrary, the enrollee is responsible for notifying the private review agent in a timely manner and obtaining certification for health care services. A private review agent shall allow any licensed hospital, physician, or responsible patient representative, including a family member, to assist in fulfilling that responsibility.

2. To assure confidentiality, a private review agent must, when contacting a physician's office or hospital, provide its certification number, the caller's name, and professional qualification to the designated utilization review representative in the physician's office or hospital.

106.02 Information Upon Which Utilization Review is Conducted

1. When conducting routine prospective and concurrent utilization review, the private review agent shall collect only the information necessary to certify the admission, procedure or treatment and length of stay.

2. A private review agent should not routinely expect hospitals and physicians to supply numerically codified diagnoses or procedures. The private review agent may ask for such coding, since if it is known, its inclusion in the data collected increases the effectiveness of the communication.

3. The private review agent shall not routinely request copies of medical records on all patients reviewed. During prospective and concurrent review, copies of medical records should only be required when a difficulty develops in certifying the medical necessity or appropriateness of the admission or extension of stay. In those cases, only the necessary or pertinent sections of the record should be required.

4. Private review agents may request copies of medical records retrospectively for a number of purposes, including auditing the services provided, quality assurance, evaluation of compliance with the terms of the health benefit plan or UR provisions. With the exception of the reviewing of records associated with an appeal or with an investigation of data discrepancies and unless otherwise provided for by contract or law, health care providers should be reimbursed the reasonable direct costs of duplicating requested records for retrospective review.

106.03 Except as otherwise provided in these standards, a private review agent should limit its initial data requirements to the following elements:

1. Patient Information

a. Name

b. Address

c. Date of Birth

d. Sex

e. Social Security Number or Patient ID Number

f. Name of Carrier or Plan

g. Plan ID Number

2. Enrollee Information

a. Name

b. Address

c. Social Security Number or Employee ID Number

d. Relation to Patient

e. Employer

f. Health Benefit Plan

g. Group Number/Plan ID Number

h. Other Coverage Available (Workers Comp., Medicare, etc.)

3. Attending Physician/Practitioner Information

a. Name

b. Address

c. Phone Number

d. Degree

e. Specialty/Certification Status

f. Tax ID or Other ID Number

4. Diagnosis/Treatment Information

a. Primary Diagnosis

b. Secondary Diagnosis

c. Proposed Procedure(s) or Treatment(s)

d. Surgical Assistant Requirement

e. Anesthesia Requirement

f. Proposed Admission or Service Date(s)

g. Proposed Procedure Date

h. Proposed Length of Stay

5. Clinical Information

Sufficient information for support of appropriateness and level of service proposed

6. Facility Information

a. Type (such as in-patient, out-patient, rehab, etc.)

b. Status (DRG exempt status, as needed)

c. Name

d. Address

e. Phone Number

f. Tax ID or Other ID Number

7. Concurrent (Continued Stay) Review Information

a. Clinical Contact Person

b. Additional Days/Services Proposed

c. Reasons for Extension

d. Diagnosis (same/changed)

e. Clinical Information (Sufficient to support, as above)

8. Admissions to Facilities Other Than Acute Medical/Surgical Hospitals

a. History of Present Illness

b. Patient Treatment Plan and Goals

c. Prognosis

d. Staff Qualifications

e. 24 Hour Availability of Staff

106.04 <u>Special Situations</u>

1. Additional information may be required for other specific review functions such as discharge planning or catastrophic case management. Second opinion information may also be required, when applicable, sufficient to support benefit plan requirements.

2. Information in addition to that described in this section may be requested by the private review agent or voluntarily submitted by the provider, when there is significant lack of agreement between the private review agent and health care provider regarding the appropriateness of certification during the review or appeal process. "Significant lack of agreement" means that the private review agent has:

a. Tentatively determined, through its professional staff, that a service cannot be certified;

b. Referred the case to a physician for review; and

c. Talked to or attempted to talk to the attending physician for further information.

3. A private review agent should share all clinical and demographic information on individual patients among its various divisions (e.g., certification, discharge planning, case management) to avoid duplicate requests for information from enrollee or providers.

106.05 Procedures For Review Determination

1. Each private review agent shall have written procedures to assure that reviews are conducted in a timely manner.

2. Each private review agent shall make certification determinations within two working days of receipt of the necessary information on a proposed admission or service requiring a review determination. Collection of the necessary information may necessitate a discussion with the attending physician or, based on the requirements of the health benefit plan, may involve a completed second opinion review.

3. A private review agent may review ongoing inpatient stays, but shall not routinely conduct daily review on all such stays. The frequency of the review for extension of the initial determination should vary based on the severity or complexity of the patient's condition or on necessary treatment and discharge planning activity. Routine concurrent review generally should not be necessary earlier than 24 hours prior to the lapse of the certified length of stay.

4. Each private review agent shall have in place written procedures for providing notification of its determination regarding certification, recertification, or extensions of previously authorized length of stay in accordance with the following:

a. When an initial determination is made to certify, notification shall be provided promptly either by telephone or in writing, to the attending physician. The notification shall be transmitted in writing to the hospital and attending physician, as well as to the enrollee or patient, within two working days.

b. A determination to certify resulting from concurrent review shall be transmitted to the attending physician by telephone or in writing within one working day of receipt of all information necessary to complete the review process or prior to the end of the current certified period.

c. If a private review agent transmits written confirmation of certification for continued hospitalization, that notification shall include the number of extended days, the new total number of days approved, and the date of admission.

d. When a determination is made not to certify a hospital or surgery facility admission or extension of a hospital stay or other service requiring review determination, the attending physician shall be notified by telephone within one working day and a written notification should be sent within one working day to the hospital, attending physician and the enrollee or patient. The written notification shall include the principal reason(s) for the determination and the way to initiate an appeal of the determination if the enrollee, patient, or their representative so chooses. Reasons for a determination not to certify shall include, among other things, the lack of adequate information to certify after a reasonable attempt has been made to contact the attending physician.

106.06 Notwithstanding language to the contrary elsewhere contained herein, if a licensed physician certifies in writing to an insurer within seventy-two (72) hours of an admission that the insured person admitted was in need of emergency admission to hospital care, such shall constitute a prima facie case of the medical necessity of the admission. An emergency admission results from sudden onset of a medical condition manifested by acute symptoms of sufficient severity that absence of immediate inpatient hospitalization could reasonably result in:

1. Permanently placing the patient's health in jeopardy;

2. Serious impairment to bodily functions; or

3. Serious and permanent dysfunction of any bodily organ or part, or other serious medical consequences.

106.07 To overcome this, the entity requesting the utilization review and/or the private review agent must show by clear and convincing evidence that the admitted person was not in need of immediate hospital care.

106.08 Private review agents shall have in place written procedures to address the failure of a health care provider, patient, or their representative to provide the necessary information for review. If the patient or provider

will not release the necessary information to the UR Organization, the UR Organization may deny certification in accordance with its own policy or that of the health benefit plan.

107 APPEALS OF DETERMINATIONS NOT TO CERTIFY

107.01 Each private review agent shall have in place procedures for appeals of determinations not to certify an admission, procedure, service or extension of stay. The right to appeal shall be available to the patient or enrollee, and to the attending physician on behalf of the patient. The procedures for appeals shall include, at a minimum, the following statement:

107.02 Any person aggrieved by a final decision of the department or a private review agent in a contested case under this act shall have the right of judicial appeal to the chancery court of the county of the residence of the aggrieved person.

107.03 Notwithstanding any provision of this act, the insured shall have the express right to pursue any legal remedies he may have in a court of competent jurisdiction.

108 EXPEDITED APPEAL

108.01 When an initial determination not to certify a health care service is made prior to or during an ongoing service requiring review, and the attending physician believes that the determination warrants immediate appeal, the attending physician shall have an opportunity to appeal that determination over the telephone on an expedited basis, within one working day. Each private review agent shall provide for reasonable access to its consulting physician(s) for such appeals. Both providers of care and private review agents should attempt to share the maximum information by phone, FAX, or otherwise to resolve the expedited appeal (sometimes called a reconsideration request) satisfactorily.

108.02 Expedited appeals which do not resolve a difference of opinion may be resubmitted through the standard appeal process.

109 STANDARD APPEAL

109.01 The private review agents shall establish procedures for appeals to be made in writing and/or by telephone.

109.02 Each private review agent shall notify in writing the patient, provider and claims administrator of its determination on the appeal as soon as practical, but in no case later that 60 days after receiving the required documentation on the appeal. The documentation required by the private review agent may include copies of part or all of the medical record and/or a written statement from the attending physician.

109.03 Prior to upholding the original decision not to certify for clinical reasons, the private review agent shall conduct a review of such documentation by a physician who did not make the original determination not to certify.

109.04 The process established by a private review agent may include a period within which an appeal must be filed to be considered.

109.05 An attending physician who has been unsuccessful in an attempt to reverse a determination not to certify should be provided, upon request, the clinical basis for the determination.

110 NOTIFICATION TO THE CLAIMS ADMINISTRATOR

110.01 Each private review agent shall forward, either electronically or in writing, a notification of certification or determination not to certify to the appropriate claims administrator for the health benefit plan.

111 CONFIDENTIALITY

111.01 Each private review agent shall have written procedures for assuring that patient-specific information obtained during the process of utilization review will be:

1. Kept confidential in accordance with applicable federal and state laws;

2. Used solely for the purposes of utilization review, quality assurance, discharge planning and catastrophic case management; and

3. Shared with only those agencies (such as the claims administrator) who have authority to receive such information.

111.02 Summary data shall not be considered confidential if it does not provide sufficient information to allow identification of individual patients.

112 STAFF AND PROGRAM QUALIFICATIONS

112.01 Each private review agent shall have utilization review staff who are properly trained, qualified, supervised and supported by written clinical criteria and review procedures. Clinical criteria and review procedures shall be established with appropriate involvement from physicians.

112.02 Nurses, physicians and other licensed health professionals conducting reviews of medical services, and other clinical reviewers conducting

specialized reviews in their area of specialty shall be currently licensed or certified by an approved state licensing agency in the United States.

112.03 A physician shall review all cases in which the private review agent has concluded that a determination not to certify for clinical reasons is appropriate. The physician should be reasonably available by telephone to discuss the determination with the attending physician.

112.04 In cases where an appeal to reverse a determination not to certify for clinical reasons is unsuccessful, the private review agent should assure that a physician in the same or similar general specialty as typically manages the medical condition, procedure or treatment under discussion is reasonably available, as appropriate, to review the case. For the purpose of this review, the phrase "reasonably available" shall mean within one working day, unless extenuating circumstances exist. These extenuating circumstances shall be in writing.

112.05 Private review agents shall utilize the following:

1. Written clinical criteria, as needed, for the purpose of determining the Appropriateness of the certification; such criteria should be periodically evaluated and updated;

2. Physician consultants or specialists who are certified by the Boards within the American Board of Medical Specialists or the American Board of Osteopathy from the major areas of clinical services;

3. A formal program for orientation and training of UR staff; and

4. Written documentation of an active Quality Assessment Program.

113 ACCESSIBILITY AND ON-SITE REVIEW PROCEDURES

113.01 Each private review agent shall provide access to its review staff by a toll free or collect call phone line, at a minimum, from 9:00 A.M. to 5:00 P.M. of each normal business day in this state.

113.02 Each private review agent shall also have a mechanism to receive timely call-backs from providers and shall establish written procedures for receiving or redirecting after-hours calls, either in person or by recording.

113.03 Each private review agent shall conduct its telephone and on-site information gathering reviews and hospital communications during the hospitals' and physicians' reasonable and normal business hours, unless otherwise mutually agreed.

113.04 Each private review agent's staff shall identify themselves by name and by the name of their organization and, for on-site reviews, should carry picture identification and the private review agent company identification card. On-site reviews should, whenever possible, be scheduled at least one business day in advance with the appropriate hospital contact. Private review agents shall agree, if so requested, that the medical records remain available in designated areas during the on-site review and that reasonable hospital administrative procedures shall be followed by on-site review staff so as to not disrupt hospital operations or patient care. Such procedures, however, should not limit the ability of the private review agent to efficiently conduct the necessary review on behalf of the patient's health benefit plan.

114 REPORTING REQUIREMENTS

114.01 The Director shall establish reporting requirements to:

1. Evaluate the effectiveness of private review agents

2. Determine if all the utilization review programs are in compliance with the provisions of these rules and regulations.

115 EXEMPTIONS

115.01 The Director may waive the requirements of these rules and regulations for a private review agent that operates solely under contract with federal government for utilization review of patients eligible for hospital services under Title XVIII of the Social Security Act (Medicare) and Title XIX (Medicaid).

115.02 No certificate is required for utilization review by any Mississippi licensed pharmacist or pharmacy, or organizations of either, while engaged in the practice of pharmacy in this state.

115.03 No certificate is required for those private review agents conducting general in-house utilization review for hospitals, home health agencies, preferred provider organizations or other managed care entities, clinics, private physician offices or any other health facility or entity, so long as the review does not result in the approval or denial of payment for hospital or medical services for a particular case. Such general in-house utilization review is completely exempt.

116 AMENDMENTS

116.01 House Bill 1330 of the Mississippi Legislature 2000 Regular Session amended Section 41-83-31, Mississippi Code of 1972, as follows:

1. 41-83-31. Any program of utilization review with regard to hospital, medical or other health care services provided in this state shall comply with the following:

    a. No determination adverse to a patient or to any affected health care provider shall be made on any question relating to the necessity or justification for any form of hospital, medical or other health care services without prior evaluation and concurrence in the adverse determination by a physician licensed to practice in Mississippi. The physician who made the adverse determination shall discuss the reasons for any adverse determination with the affected health care provider, if the provider so requests. The physician shall comply with this request within fourteen (14) calendar days of being notified of a request. Adverse determination by a physician shall not be grounds for any disciplinary action against the physician by the State Board of Medical Licensure.

    b. Any determination regarding hospital, medical or other health care services rendered or to be rendered to a patient which may result in a denial of third-party reimbursement or a denial of pre-certification for that service shall include the evaluation, findings and concurrence of a physician trained in the relevant specialty or subspecialty, if requested by the patient(s physician, to make a final determination that care rendered or to be rendered was, is, or may be medically inappropriate.

    c. The requirement in this section that the physician who makes the evaluation and concurrence in the adverse determination must be licensed to practice in Mississippi shall not apply to the Comprehensive Health Insurance Risk Pool Association or its policyholders and shall not apply to any utilization review company which reviews fewer than ten persons residing in the State of Mississippi.

2. Section 2. This act shall take effect and be in force from and after July 1, 2000.

117 CERTIFICATION OF REGULATION

This is to certify that the above **PUT REGULATION NAME HERE** was adopted by the Mississippi State Board of Health on Put Date Here to become effective Put Date Here .

Brian W. Amy, MD, MHA, MPH
Secretary and Executive Officer